Case Number:	CM13-0044625		
Date Assigned:	12/27/2013	**Date of Injury:**	12/07/1982
Decision Date:	03/11/2014	**UR Denial Date:**	10/08/2013
Priority:	Standard	**Application Received:**	10/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York and Tennessee. He/she has been in active clinical practice for more than five years and is currently working least at 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 52-year-old female who was injured on January 2, 1991. The patient continued to experience severe pain in the lumbar spine. Physical examination showed tenderness to the lumbar paraspinal musculature and positive straight leg raise test. MRI of the lumbosacral spine done on July 7, 2013 showed spinal fusion at L4, L5, and S1 with minimal degenerative changes at L2-3 and L3-4. Diagnoses included disc lesion of the lumbar spine, status post lumbar spinal fusion, and failed back syndrome. Prior treatment included surgical intervention, acupuncture, and medications. Request for authorization for lumbar epidural steroid injection with Duramorph was submitted on September 26, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Lumbar epidural steroid injection with Duramorph (morphine): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines AMA Guides 9Radiculopathy Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block. In this case there is no documentation of radiculopathy signs or symptoms. Findings on MRI of the lumbosacral spine are not consistent with radiculopathy. Criteria are not met for epidural steroid injections. In addition MTUS and ODG do not comment on the use of Duramorph in epidural injections. The lack of information does not allow determination for medical necessity and safety.